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PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))

Docket Number (Optional)

Mail to: Mail Stop Petition
Commissioner for Patents
P.O. Box 1450
Alexandria VA 22313-1450
Fax: (571) 273-8300

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (571) 272-3282.

Patent Number: 6989740

Application Number: 10/073236

Issue Date: 01/24/2006

Filing Date: 02/13/2002

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366(c) and (d).

Also complete the following information, if applicable:

The above-identified patent

☐ is a reissue of original Patent No. _____ original issue date _____;
original application number _____,
original filing date _____.

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application _____ filed on _____.

CERTIFICATE OF MAILING OR TRANSMISSION (37 CFR 1.8(a))

I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is

(1) being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 OR

(2) transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (571) 273-8300.

09/11/2010
Date

Signature

JOSEPH AKWO TABE
Typed or printed name of person signing Certificate

[Page 1 of 4]

If you need assistance in completing the form, call 1-800-PTO-9199 and select option 2.

09/13/2010 GKHLOK 00000006 6989740

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1. SMALL ENTITY

☑ Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g)

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity			Small Entity		
Amount	Fee	(Code)	Amount	Fee	(Code)
☑ $ _____	3 ½ yr fee	(1551)	☑ $ 490	3 ½ yr fee	(2551)
☐ $ _____	7 ½ yr fee	(1552)	☐ $ _____	7 ½ yr fee	(2552)
☐ $ _____	11 ½ yr fee	(1553)	☐ $ _____	11 ½ yr fee	(2553)

MAINTENANCE FEE BEING SUBMITTED $ _____

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of $ 600 (Fee Code 1557) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee.

SURCHARGE FEE BEING SUBMITTED $ 600

5. MANNER OF PAYMENT

☐ Enclosed is a check for the sum of $ _____

☐ Please charge Deposit Account No. _____ the sum of $_____ .

☑ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Director is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____ .

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37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

Signature

09/11/2010
Date

JOSEPH AKWO TABE
Type or printed name

Registration Number, if applicable

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

My wife was pregnant and had some complications which needed medical attentions.

(Please attach additional sheets if additional space is needed)

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7. OVERPAYMENT

As to any overpayment made, please

☐ Credit to Deposit Account No. _____

OR

☑ Send refund check

WARNING:

Petitioner/applicant is cautioned to avoid submitting personal information in documents filed in a patent application that may contribute to identity theft. Personal information such as social security numbers, bank account numbers, or credit card numbers (other than a check or credit card authorization form PTO-2038 submitted for payment purposes) is never required by the USPTO to support a petition or an application. If this type of personal information is included in documents submitted to the USPTO, petitioners/applicants should consider redacting such personal information from the documents before submitting them to the USPTO. Petitioner/applicant is advised that the record of a patent application is available to the public after publication of the application (unless a non-publication request in compliance with 37 CFR 1.213(a) is made in the application) or issuance of a patent. Furthermore, the record from an abandoned application may also be available to the public if the application is referenced in a published application or an issued patent (see 37 CFR 1.14). Checks and credit card authorization forms PTO-2038 submitted for payment purposes are not retained in the application file and therefore are not publicly available.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.

_____ 09/11/2010
Signature(s) of Petitioner(s) Date

JOSEPH AKWO TABE _____
Typed or printed name(s) Registration Number, if applicable

11700 OLD COLUMBIA PIKE, SUITE 2010 240-462-0487
Address Telephone Number

SILVER SPRING, M.D 20904
Address

ENCLOSURES:

☑ Maintenance Fee Payment
☑ Statement why maintenance fee was not paid timely
☑ Surcharge under 37 CFR 1.20(i)(1) (fee for filing the maintenance fee petition)
☑ Other: SUPPORTING DOCUMENTS

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FUNCTIONAL ASSESSMENT

Self Care	Walking ☒ Independent ☐ Uses a device ☐ Help of Another ☐ Totally Dependent Stairs ☐ Independent ☐ Uses a device ☐ Help of Another ☐ Totally Dependent Eating ☐ Independent ☐ Uses a device ☐ Help of Another ☐ Totally Dependent Bathing/Dressing ☐ Independent ☐ Uses a device ☐ Help of Another ☐ Totally Dependent Bowel/Bladder ☐ Independent/continent ☐ Home with foley Assistive Devices/Lines sent with patient ☐ None ☐ _____
Communication	Language ☐ English ☐ Spanish ☐ Other: Translator _____ Devices ☐ None ☐ Glasses/Contacts ☐ Hearing Aids ☐ Other:
LOC/Orientation	☐ Alert ☐ Oriented to person, place, time, event ☐ Other
Condition at Discharge	T_____ P_____ R_____ BP_____ ☐ Stable ☐ Other:
Allergies	☐ NKA ☐ Other:
Rhogam	☐ N/A ☐ Given Mother's blood type _____ Baby's blood type _____ Rubella ☐ Immune ☐ Vaccine Given ☐ Vaccine Refused

DISCHARGE

Call Doctor if you have:	1. Bleeding that soaks a pad in less than 1 hour 2. Bleeding mixed with clots the size of an egg or larger 3. Chills, fever over 100.4 4. Severe abdominal pain 5. Burning or frequent urination 6. Red streaks or pain in the breasts 7. Red streaks or pain in legs 8. Drainage from incision 9. Hot, swollen, painful stitches 10. Foul smelling vaginal discharge 11. Trouble coping with the "Baby Blues"
Other Instructions	

Medications	Name of Medication	Purpose	When to take	Amount	Special Instructions	Prescription Given
					☐ FDI	☐ Yes ☐ No
					☐ FDI	☐ Yes ☐ No
					☐ FDI	☐ Yes ☐ No
					☐ FDI	☐ Yes ☐ No

Diet	☐ Diet as tolerated ☐ Increase fluids ☐ Continue Prenatal vitamins ☐ Other:
Activity	☐ No Limits ☐ Don't climb stairs ☐ No heavy lifting ☐ Avoid driving ☐ No sexual activity until after MD appt. ☐ Other:
Follow-up as indicated	Washington Adventist Hospital Social Services Department 301-891-5465 Other Agencies:
Follow-up Appointments	Name _____ call _____ for appointment in _____ Name _____ call _____ for appointment in _____ Name _____ call _____ for appointment in _____
Discharge	☐ Home ☐ Other: Via ☐ Wheelchair ☐ Other:
I have been taught, understand, and received a copy of these DISCHARGE INSTRUCTIONS Patient's/Family Signature	Nurse Signature, Date

Hospital Phone Numbers: Unit 3100 Post Partum 301-891-6300 Newborn Nursery 301-891-5498 Lactation Consultant 301-891-6207

ADVENTIST HEALTHCARE
Washington Adventist Hospital

Obstetric Discharge

WAH 646-197 Rev. 4/99

Patient Identification

ASHU ,SUSAN
12044999 Dr: OBSTETRICS, DPW
Admit:02/11/10 F 30 11/16/79
MR # 0837134 WAH 3100

BABY CARE	INFORMATION	DATE & INITIALS TEACHING CODES	BABY CARE	INFORMATION	DATE & INITIALS TEACHING CODES
Watch Newborn Channel for Baby Care			Hiccups Sneezing	Normal in newborn	
Handwashing	Viruses and bacteria are transmitted by hands. Wash frequently				
Infant Safety in Hospital	Never leave baby out of line of sight, or give baby to unidentified staff, mother/baby bands.		Skin Care Diaper Rash	No oils or lotions on head, face or groin. Frequent changes and leave diaper open and exposed to air if rash.	
Crying as Communication	May be hungry, need to pass gas or burp, have diaper changed, be tired or want to be picked up. Never shake baby.		Bath	Sponge or tub baths. No need to bathe more than every other day in first week of life.	
Positioning	Side or back. Not on stomach.		Soaps	Use mild soap. No perfumes.	
Bulb Syringe – Choking	Use bulb to clear nose and mouth of secretions if choking. Keep it close.		Nail Care	Use emery board (fine side). No cuticle scissors or nail clippers.	
Stools	First stool (black-green) usually passed in 1st 24 hrs. Then stools are greenish, then seedy soft yellow.		Temperature Taking	Check temperature if you think baby is sick or otherwise instructed by your doctor. Use armpit (axilla). Normal 97.8° - 99.2°	
Urine	1st urine in 1st 24hrs. About 6-8 diapers after 48 hrs.		Clothing	Flame retardant, comfortable. Do not overdress or wrap too tightly.	
Cord	Keep dry. Fold diaper below cord. Cord falls off 1-2 weeks.		Jaundice ☐ Jaundice sheet given	A yellow color in skin and eyes common in 1st few days of life. Blood test (bilirubin) measures amount of yellow pigment.	
Diaper Change	Check every 2-3 hours if awake, and change if wet or dirty. Wash girls front to back.		Environment	Smoke free, fire detectors. Avoid extremes of temp in house. No soft mattresses or pillows.	
Genitals – Girl	White or pink discharge or cheesy material normal in newborn		Car Seat	Follow manufacturer's directions for installation.	
Circumcision Care	Apply petroleum jelly to tip of penis every diaper change for 2-3 days.		Breast Feeding	Latching, positioning, frequency, length, breast feeding log, discussed.	
Uncircumcised Care	No need to retract foreskin.		Bottle Feeding	Positioning, frequency and preparation discussed.	

Initials	Signature, title	Initials	Signature, title

Teaching Codes

Teaching Method	Person Taught	Teaching Outcome
V = Verbal W = Written material D = Demonstration A = Audio Visual	P = Parent S = Significant Other T = Translator	VU = Verbalize, understood RD = Return Demo

SIGNS AND SYMPTOMS OF ILLNESS. CALL PEDIATRICIAN.
- Redness, discharge or foul odor from eyes, circumcision or umbilical cord
- Less than 4 wet diapers per day by 4 days old
- Frequent, explosive, watery stools that soak through the diaper
- Axillary temperature of less than 97.4° or greater than 100°F
- Poor feeding, weak suck, or no interest in eating
- Vomiting forcefully several times, not just spitting up
- Worsening jaundice
- Turning blue or gray or stops breathing
- Excessive irritability or excessive sleepiness
- Call 911 for any emergency with your baby.

INSTRUCTIONS
- ☐ Second dose Hepatitis B Vaccine to be given in one month Schedule with Pediatrician
- ☐ Second PKU to be done in 2-3 weeks
- ☐ Bilirubin test in A.M. ☐ at WAH lab ☐ at Pediatrician Office

FEEDINGS (type, amount, frequency)

Medications ☐ None	Name	Purpose	When to take	Amount	Special Instructions	Prescription Given
					☐ FDI	☐ Yes ☐ No
					☐ FDI	☐ Yes ☐ No

Follow-up Appointments

Name _____ call _____ for appointment in _____

Name _____ call _____ for appointment in _____

Discharge ☐ Home with Car Seat ☐ Other _____ ☐ Immunization Book given ☐ Pediatrician Letter given

Condition at Discharge

I have been taught, understand, and received a copy of these DISCHARGE AND TEACHING INSTRUCTIONS

Mother's Signature

Nurse Signature, Date/Time:

Nursery 301-891-5498 Maternity 301-891-5400 Lactation Consultant 301-891-5687 (WCMH) Social Work Dept. 301-891-5445

Washington Adventist Hospital

TEACHING AND DISCHARGE INSTRUCTIONS

Patient Label

ACCT: ASHU ,BOY SUSAN
12045176 Dr: STAFF PEDIATRICIAN,N
Admit:02/12/10 M O 02/12/10
MR # 0839515 WAH 3300

030-144 (Rev. 07/05) WHITE: CHART COPY YELLOW: PARENT COPY

Section 1. Physician (LIP) Discharge Instructions (complete for patients discharged to home / similar residence) If preprinted patient instructions are used or there is a dictated patient summary sheet for another facility, go to Section 4 and complete.

FOLLOW UP APPOINTMENTS – It is important for you to keep these appointments:

- ☒ Make appointment with: Dr PLATE Phone# 301 891 6000 In MON 3/1
- ☒ Make appointment with: Dr OB CLINIC Phone# 301 891 6647 In 2 WKS
- ☐ Contact Health & Wellness at 1-800-542-5096 for follow up community services, diabetes counseling, smoking cessation.
- ☐ Other appointments:

WHEN TO CALL YOUR DOCTOR - Call your doctor immediately if you have any of the following:

New or Worsening Symptoms:	Post-Procedure Symptoms:	Other Symptoms:
✓ Increased fatigue and weakness	✓ Fever more than 101	☐ Increased/decreased urination
✓ Shortness of breath/difficulty breathing at rest, when lying down or with activity	✓ Increased tenderness/swelling/warmth at incision site	☐ Dry cough / wheezing
✓ Increased swelling of feet, legs, abdomen	✓ Drainage/odor from incision site	☐
✓ Weight gain 2-3 lbs in one day	✓ Bleeding from incision site	☐
✓ Chest pain	✓ Increased/unexpected pain	☐
	✓ Nausea/vomiting	

ACTIVITY

☐ Usual ☐ No stair climbing until ☒ No heavy lifting until CLEARED BY OB ☐ No driving until
☐ No walking until ☒ No sexual activity until 6 WKS ☐ No bathing/shower until
☐ Other: POSTPARTUM

DIET

☒ Regular ☐ Full Liquid ☐ Clear Liquid ☐ ADA ☐ Diabetic ADA calories/day ☐ Other:
Restrictions: ☐ Salt gms/day ☐ Cholesterol ☐ Liquids cups/day ☐ Alcohol ☐ Other:
☐ Tube Feeding: ☐ Supplement:

TREATMENTS / PERSONAL CARE

Weigh and record your weight every day. If you have heart or kidney failure.
Stop smoking/tobacco use. If you smoke, call for smoking cessation assistance: 1-800-542-5096
Wound Care: CLEAN VAG CARE AS INSTRUCTED, HOME HEALTH CARE SETUP
Additional Instructions:
Vaccinations Received in Hospital: ☐ Pneumovax DATE: ☐ Influenza DATE: ☐ Other:

Section 2: Additional Services (community resources/referrals and other arranged assistance)

Home Health: 301 891 5389 Phone# Services: WOUND CARE Start Date: 1/26/10
Equip Co: Phone# Other: Phone#

Section 3: Nursing Assessment/Summary (complete for all patients)

Reason for Discharge/Transfer: ☑ MD discharge order ☐ Expired ☐ AMA ☐ Transfer
Discharge to: ☐ Home ☐ Other Residence Transfer to: ☐ Non-Acute Facility ☐ Acute Facility ☐ Transfer/Discharge Summary & chart copied*
Via: ☐ Walking ☑ Wheelchair ☐ Stretcher Mode: ☐ Car/Van ☐ Ambulance ☐ By: ☐ Self ☐ Family/Friend ☐
Valuables Sent: ☐ Denture: Upper Lower ☐ Glasses/Contacts ☐ Hearing Aid: Right Left ☐
☐ Prosthesis (type): RUE Assist Device: ☐ Cane ☐ Walker ☐ Isolation: ☐ Contact ☐ Droplet ☐ Airborne
Biopsychosocial Status: ☑ No change from last assessment ☐ Changes from last assessment documented
Limitations: ☐ None ☐ Vision ☐ Communication ☐ Hearing ☐ Paralysis ☐ Amputation ☐ Other:
Self Care: (I=Independent; NA=Needs Assist; T=Total Assist) I Walking I Eating I Dressing I Bathing I Elimination
Misc: ☑ Continent ☐ Incontinent Dates: Last BM: Foley Insert: IV/PICC Insert: Other:
☐ Skin Intact ☐ Skin not Intact: ☐ Incision, ☐ Decubitus, ☐ Abrasion Size: Location: ABD AREA & DRESSING

[*The transfer summary, progress notes, patient discharge medication reconciliation list & nursing and allied health records reflect the current biopsychosocial status (condition) of the patient & progress made toward goals]

☐ Patient ☐ Family /SO Instructed/verbalizing understanding: Date: 2.25.10 ☐ N/A

Nurse providing Instruction: Unit Phone# 5594 Discharge Date: 2/25/10 Time: 1530

Original for Chart / Copy for Patient or Receiving Facility

Washington Adventist Hospital

Discharge Instructions

Page 1 Of 2

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ASHU, SUSAN

02/19/2010 F 30Y 11/16/1979 2200

MR# 837134 WAH

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PATIENT DISCHARGE RECONCILIATION

ASHU, SUSAN
12046882 BED#: 2207-2 AGE: 30Y MR#: 837134 SEX: F Ht: 5FT 9IN UNIT: 2200 DOB: 11/16/1979 Wt: 154LB 0OZ

PREGNANCY; No Known Food Allergies

Ordered Medications - Review medications; order as needed and discard sheet.

D5W/LACTATED RINGERS (D5W/LACTATED RINGERS)
VOL: 1000 ml @125 ml/hr 8 hrs
Route: Intravenously
Additional Instructions:
REASON:
Instructions

DEXTROSE 5% IN WATER (D5W)
VOL: 50 ml @100 ml/hr 0.50 hrs
REASON:

CEFTRIAXONE (ROCEPHIN)
DOSE: 1 GM
Route: Intravenously
Additional Instructions: *REFRIGERATE*
REASON:
Instructions every 12 hours

DOCUSATE SODIUM (COLACE)
DOSE: 100 MG = 1 CAP
Route: By mouth
Additional Instructions:
REASON:
Instructions twice daily

ENOXAPARIN SODIUM (LOVENOX)
DOSE: 40 MG = 0.4 ML
Route: Subcutaneously -under the skin
Additional Instructions: POD#1 AT 0800 FOR 10 DAYS.
REASON:
Instructions daily at 9:00 am

FERROUS SULFATE (FERROUS SULFATE)
DOSE: 325 MG = 1 TAB
Route: By mouth
Additional Instructions: WITH MEALS TWICE A DAY
REASON:
Instructions MEALS

PRN Medications - Review medications; order as needed and discard sheet.

ACETAMINOPHEN (TYLENOL)
DOSE: 650 MG = 2 TAB
Route: By mouth
Additional Instructions: FEVER > 100.4
REASON: FEVER
Instructions every 4 hours as needed

OXYCODONE/APAP 5-325 (PERCOCET)
DOSE: 1 TAB = 1 TAB
Route: By mouth
Additional Instructions:
REASON: PAIN SCAL 2-5
Instructions every 4 hours as needed

OXYCODONE/APAP 5-325 (PERCOCET)
DOSE: 2 TAB = 2 TAB
Route: By mouth
Additional Instructions:
REASON: PAIN SCAL 6-10
Instructions every 4 hours as needed

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DISCHARGE MEDICATION RECONCILIATION
(Page 1 Of 1)
For Reference Only

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02/19/2010 F 30Y 11/16/1979 2200
MR# 837134 WAH

...rge Medication Section

...ations: Sections A and B represent the complete list of the medications the patient is to take upon leaving the hospital ...ed Discharge Instructions: Provide one copy for patient and one for chart; Complete HOME MEDICATION list ...below. Complete NEW MEDICATION list if new meds are not on the pre-printed instructions. ...atients transferring to another facility Complete HOME MEDICATION list and signature below - indicating those ... to be taken at transfer facility; include new medications in transfer/discharge summary or add to NEW list below. ...MEDICATION List: Check box (☑) if patient to continue (Yes) or stop (No); *Recommend - cross out those to stop* ...fast L=lunch D=dinner BT=bedtime

...dmission Home Medication List Collected on: 02/20/2010

No	Medication	Amount	When To Take	Purpose/Special Instructions
☑	Prenatal Vitamins		daily	
☑	Percocet		as needed	
☑	Ceftin		twice daily	
☑	Ferrous Sulfate		twice daily	

B. NEW MEDICATION List: Review current hospital medications. In addition to the home medications above, list any other medications the patient is to take upon leaving the hospital. B=breakfast L=lunch D=dinner BT=bedtime

Medication Name	Amount	When to Take					Purpose/Special Instructions
		B	L	D	BT	Other	

This is a complete list of medications the patient is to take upon discharge.

Physician (MP) signature: [signature]

Original for Chart / Copy for Patient or Receiving Facility

Washington Adventist Hospital

Discharge Instructions

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02/19/2010 F 30Y 11/16/1979 2200

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